Kansas Governor's Council on Medicaid Expansion

Tuesday, October 29, 2019

AGENDA

- 10:00 AM **Welcome**
- 10:15 AM **Understanding the Medicaid Expansion Population**
- 10:30 AM **Section 1332 and Section 1115 Medicaid Demonstration Waivers**
- 11:15 AM **Experiences with Medicaid Expansion**
- 12:30 PM **Lunch**
- 1:15 PM **Discussion and Next Steps**
- 2:00 PM **Adjourn**

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Who Are The People In The Medicaid Expansion Population?

October 29, 2019

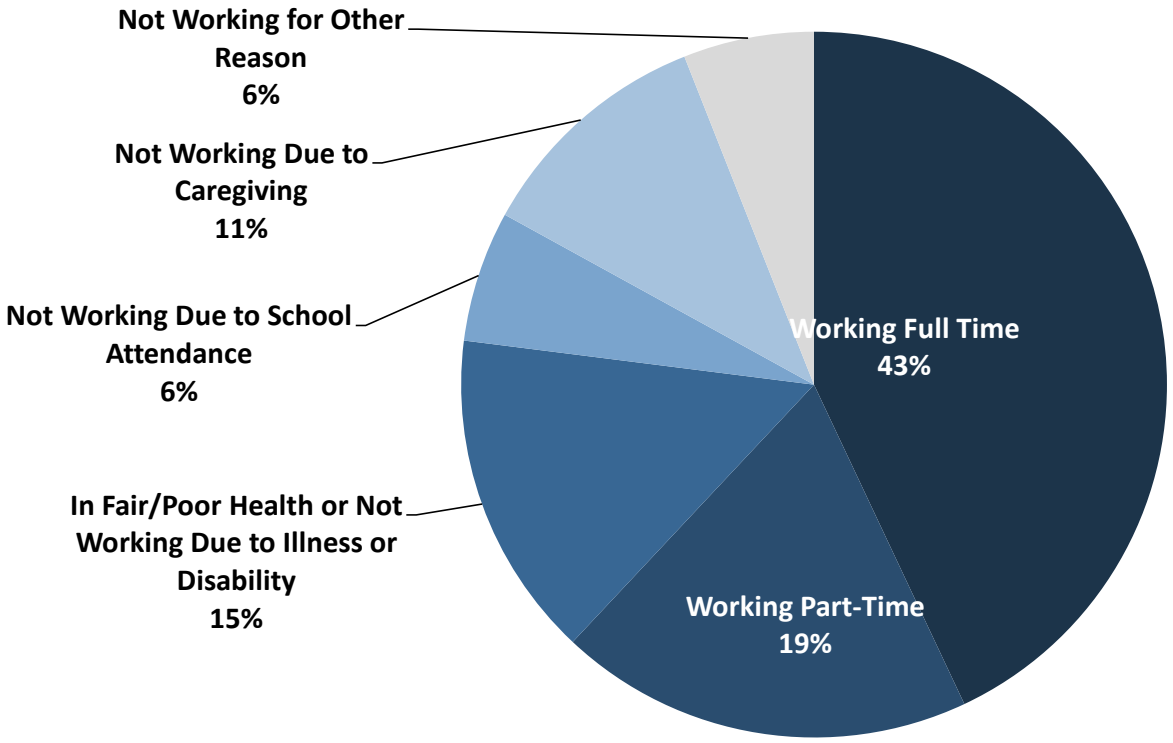
National View

- Diverse Group of People:
  - Parents and “childless” adults
  - People in good health and people with chronic conditions
  - Workers, students, caretakers (caring for children, grandchildren, other family members)
  - Predominantly ages 25-34 but many ages 45-64

Sources: NHeLP. The Faces of Medicaid Expansion: Filling Gaps in Coverage, 2017. https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2017/05/FacesofMedicaid-Expansion-JL-5.22.17.pdf;; Census Bureau's American Community Survey, 2008-2017.

Most Adult Medicaid Enrollees Work

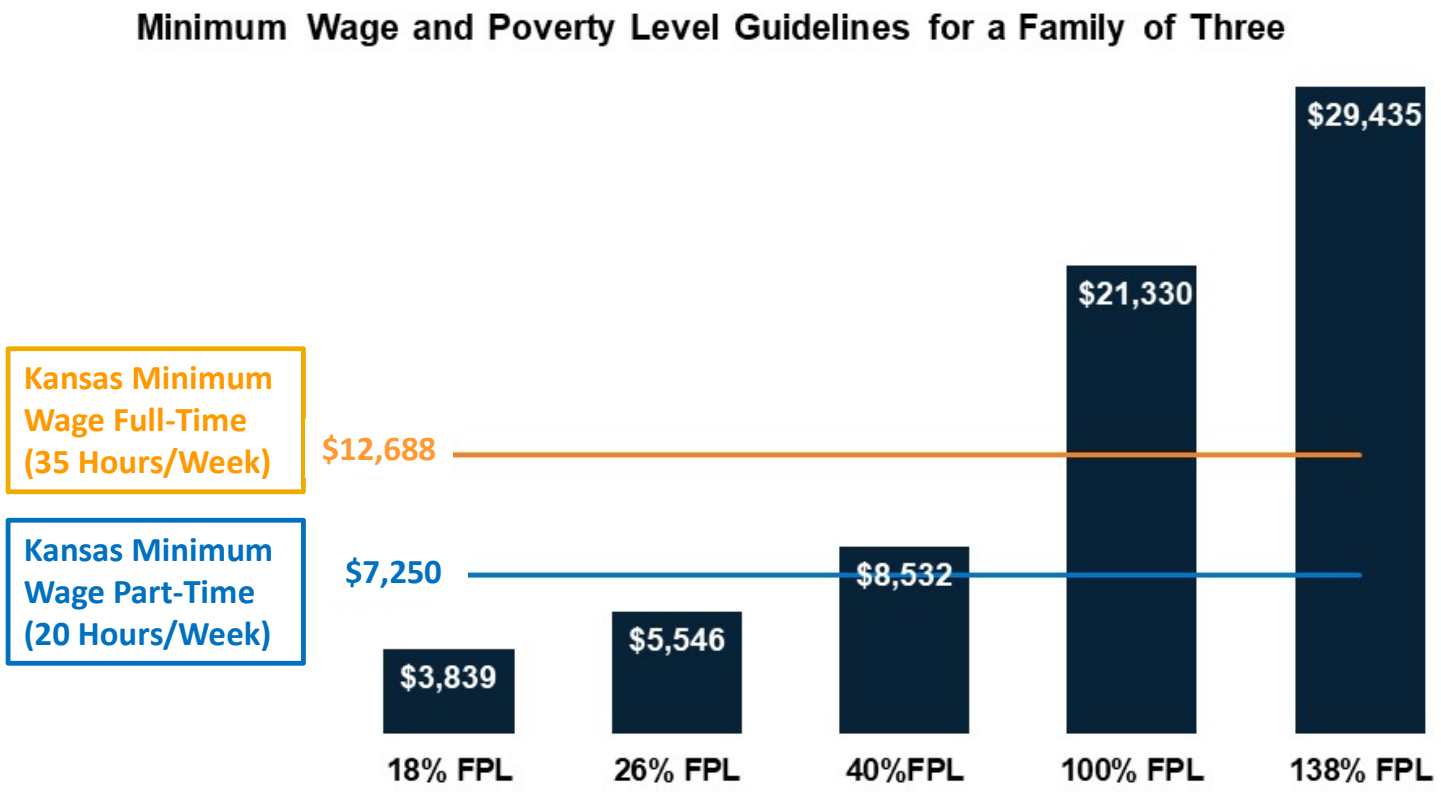
Work Status Among Non-Dual, Non-SSI, Medicaid Adults, 2016



Total of 23.5 million people.

Source: Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses, KFF, June 2018.

Annual Earnings at Kansas Minimum Wage Compared to the Poverty Line for a Family of Three, 2019

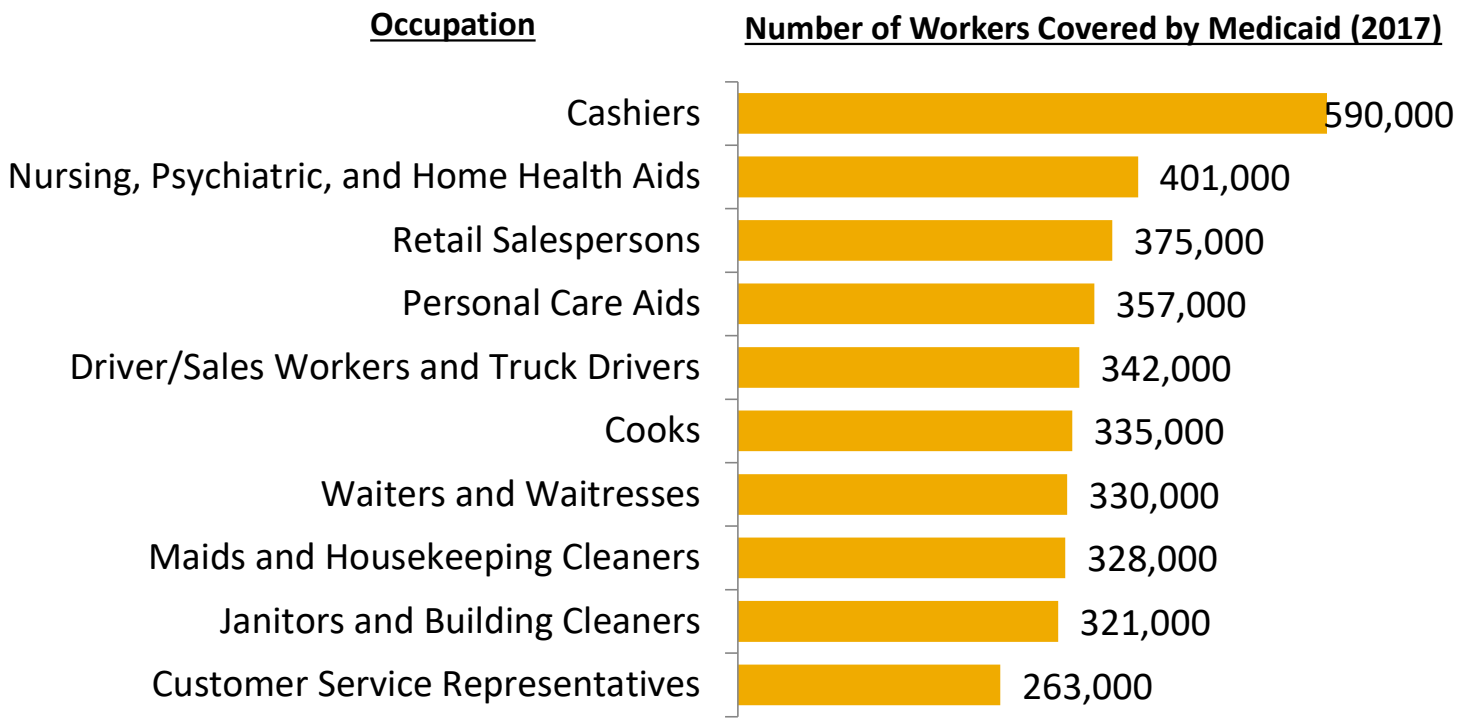


Focus: Low-Income Workers

- Low-income workers experience enormous variability in weekly incomes and number of hours worked, even for full-time jobs. The lowest income workers report the most irregular work schedules.
  - A study showed that Medicaid enrollees in Kentucky averaged 36 hours of work per week during the weeks that they had work, but only 36% of enrollees were able to work consistently 52 weeks per year.
- Nationally, among low-income workers who worked part-time, 45% cited job related reasons, 18% cited child care or family obligations, 15% cited school or training, and 9% cited health/medical reasons. Over half of workers below poverty cited job related reasons work working part-time.

Source: Searing A. State Medicaid Work Rules Ignore the Reality of Working Life for Americans in Low Wage Jobs. Georgetown Center for Children and Families, March 2018: https://ccf.georgetown.edu/2018/03/16/state-medicaid-work-rules-ignore-the-reality-of-working-life-for-americans-in-low-wage-jobs/. Gangopadhyaya A, Kenney G. Updated: Who Could Be Affected by Kentucky's Medicaid Work Requirements, and What Do We Know about Them? Urban Institute, March 2018. https://www.urban.org/sites/default/files/publication/96576/3.26-ky-updates_finalized_1.pdf Williamson A, et al. ACA Coverage Expansions and Low-Income Workers. KFF, June 2016. https://www.kff.org/report-section/aca-coverage-expansions-and-low-income-workers-issue-brief/

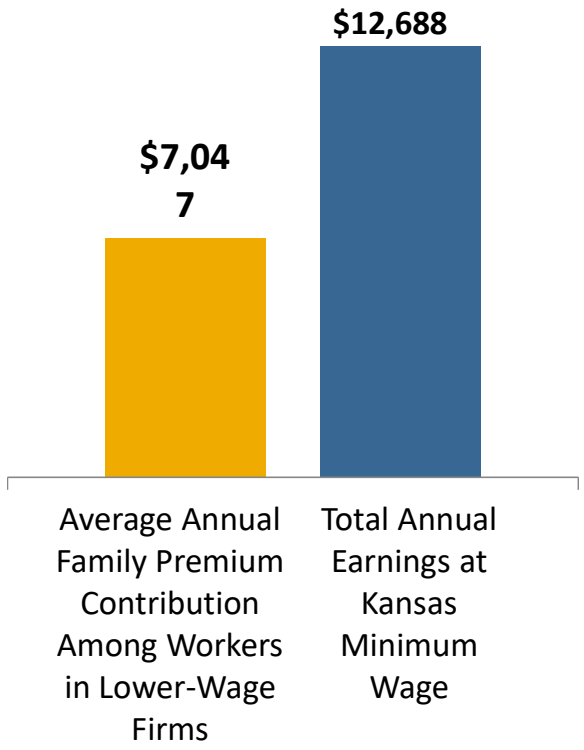
Occupations With Largest Number of Workers Covered by Medicaid



Source: March 2018 Current Population Survey.

Employer Health Benefits in 2019

- Employer-sponsored health insurance covers over half (57%) of the non-elderly population.
- But 71% of nonelderly uninsured low-income workers were not offered health benefits through their employer.
- Firms with many lower-wage workers have a lower health insurance take-up rate compared to firms with fewer lower-wage workers (51% vs. 78%).
- Workers with coverage at lower-wage firms pay an average of $7,045 for a family premium (higher than the premium paid by workers at other firms)



Source: March 2018 Current Population Survey, Annual Social and Economic Supplement; Claxton G, et al. Employer Health Benefits 2019 Annual Survey. KFF, 2019. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019

Cost-Related Barriers to Care

- The most common reason cited for being uninsured is cost.

- In 2017, uninsured nonelderly adults were over twice as likely as their insured counterparts to have had problems paying medical bills in the past 12 months.

- One in five uninsured adults in 2017 went without needed medical care due to cost.

Source: KFF. Key Facts About the Uninsured, December 2018. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population

Contact Information

Cindy Mann
Partner
Manatt Health

202.585.6572

cmann@manatt.com

Medicaid Covers US- American Cancer Society

American Cancer Society Video on Marcillene

American Cancer Society Video on Lisa

Trailer for “Critical Condition” Documentary

Section 1332 State Innovation Waiver Process

Tuesday, October 29, 2019

Individual Market Basics

Population

- The individual market offers coverage options for individuals who are not eligible for employer sponsored health insurance or public health insurance programs such as Medicare or Medicaid

Exchanges

- Coverage for the individual market is most commonly offered on the federal and state health insurance exchanges

Subsidies

- On the exchanges, individuals with incomes between 100-400% of the federal poverty line are eligible for advanced premium tax credits (APTCs) to cover part of the premium cost of insurance
- Individuals between 100-250% of the federal poverty line are eligible for lower out-of-pocket cost sharing (i.e. lower copays, coinsurance, and deductibles)

Section 1332 State Innovation Demonstration Basics

- Section 1332 allows states to waive certain provisions of the Affordable Care Act (ACA) to pursue alternative coverage approaches for the individual insurance market for up to five years
- State innovation demonstrations through Section 1332 apply only to the individual market and do not apply to Medicaid
- States may receive a "pass-through" of federal funds that would have otherwise been applied to premium tax credits had the state not received the waiver

States Can Waive

- Individual mandate
- Employer mandate
- Exchange structure, including eligibility and enrollment
- Qualified health plan certification
- Essential health benefits
- "Metal" tiers for plans
- Premium and cost-sharing assistance
- Single Risk Pool

States Cannot Waive

Insurance reforms including:

- Dependent coverage up to age 26
- No lifetime or annual limits
- No pre-existing condition exclusions (guaranteed issue)
- Adjusted community rating
- Medical Loss Ratio (MLR)

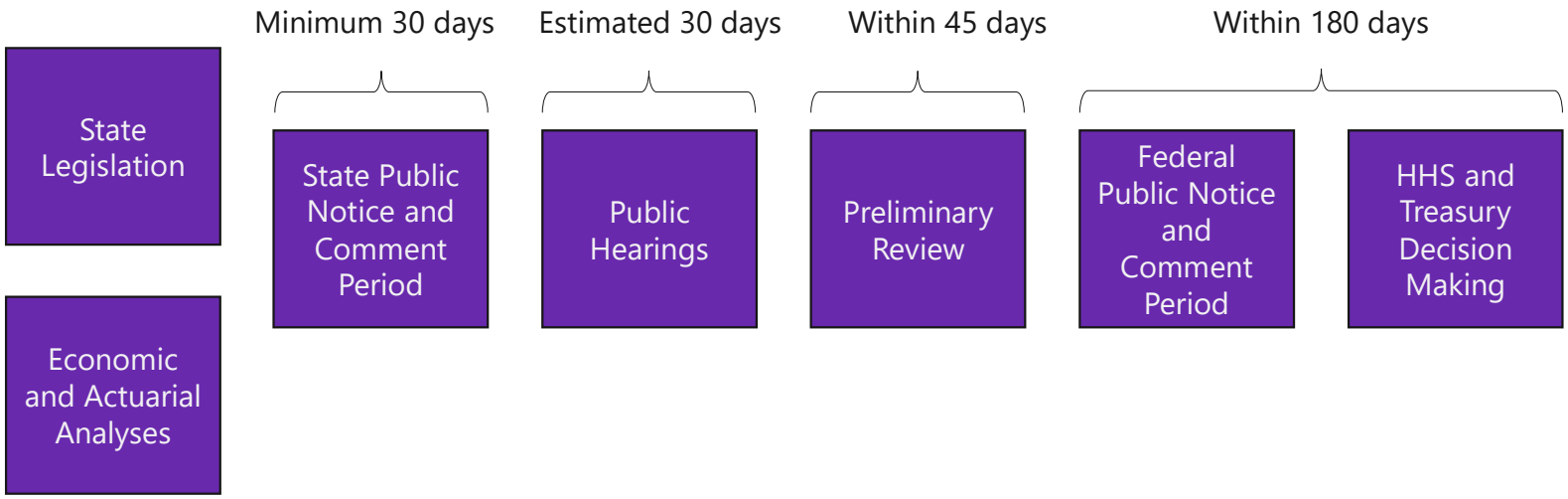
Section 1332 Guardrails

Under federal law, all Section 1332 waivers must satisfy the following guardrails:

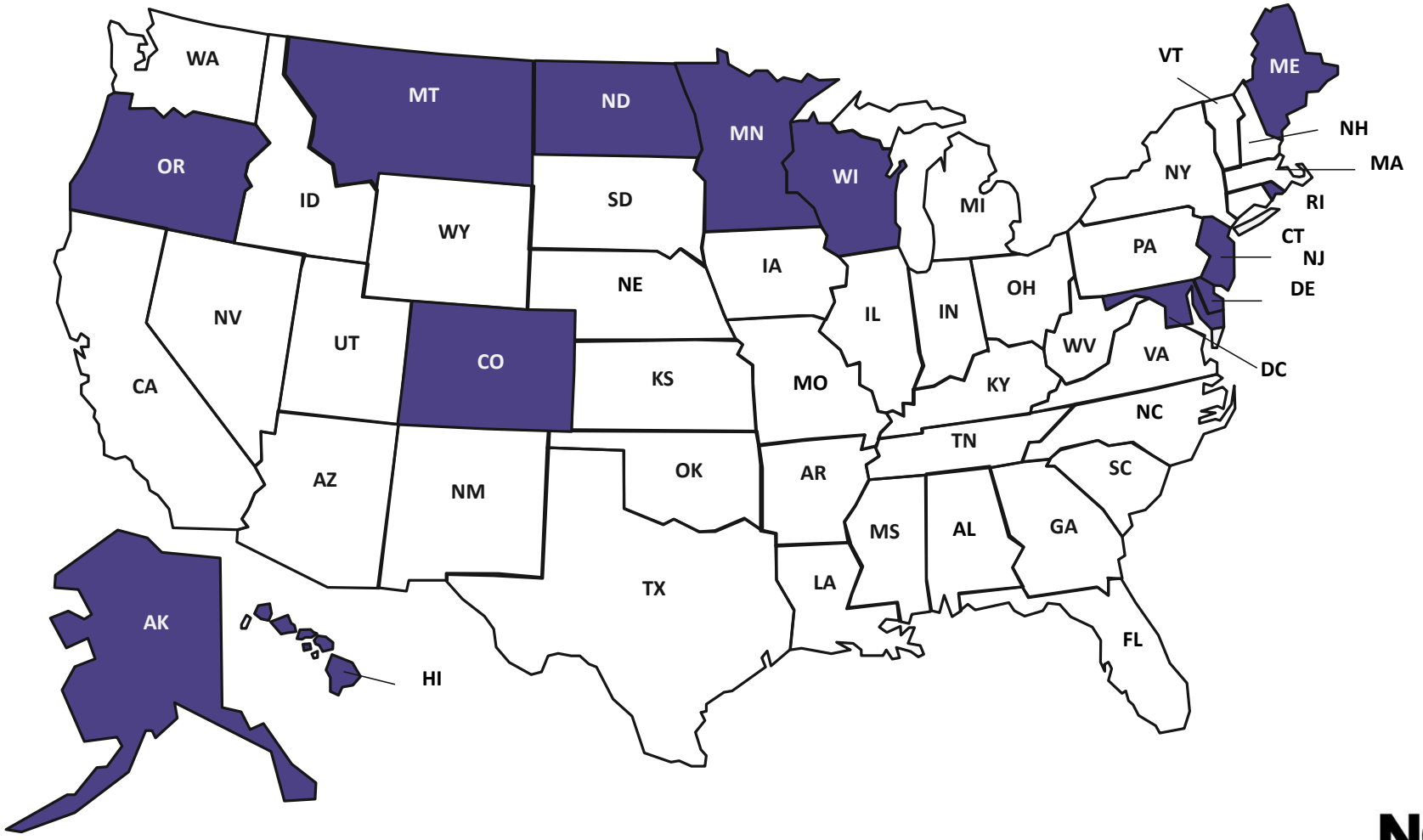
Coverage Availability	Coverage will be provided to a comparable number of individuals as would receive coverage absent the waiver
Coverage Affordability	Coverage will be as affordable for individuals as it would be absent the waiver
Comprehensiveness of Coverage	The scope of benefits will be at least as comprehensive as benefits required absent the waiver
Deficit Neutral	The waiver will not increase the federal deficit

CMS and IRS released guidance in 2018 which added some additional flexibilities in the interpretation of the guardrails

Section 1332 Waiver Process Timeline



States with Approved Section 1332 Waivers



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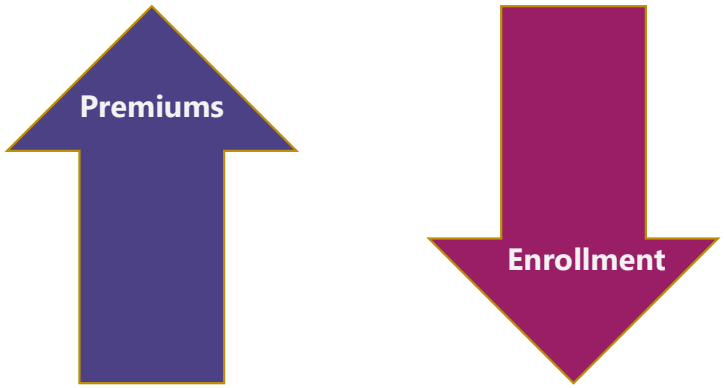
How Reinsurance Programs Work

- In a reinsurance program, health plans are reimbursed for a portion of high-cost claims, which offsets the risk of covering individuals with high-cost claims

Without Reinsurance



Premiums increase to compensate for risk pools with high-cost enrollees

Enrollment in private health insurance market decreases as individuals are priced out of market

With Reinsurance

Insurers offer lower premiums because their risk of covering high-cost enrollees is offset by the reinsurance

Enrollment in private health insurance market increases as more individuals are able to afford lower premiums

Medicaid Section 1115 Demonstrations

- Under section 1115 of the Act, the Secretary of Health and Human Services has the authority to waive federal requirements and authorize new funding if a demonstration is likely to assist in promoting the objectives of the Medicaid program
- Demonstrations allow a state to continue to receive federal funds without complying with all the federal Medicaid requirements, as approved by the federal government
- As of August 2019, 40 states have at least one approved Section 1115 demonstration; 18 states have at least one demonstration pending with the federal government

How Can States Coordinate 1332 and 1115 Waivers?

- In statute, states are authorized to submit a "coordinated waiver application" for Section 1332 individual market and Medicaid Section 1115 Demonstrations, though the application processes and review are separate

Key Differences between Section 1332 and Section 1115 Waivers		
	Section 1332 Waivers	Section 1115 Waivers
Waivers evaluated by	Center for Consumer Information and Insurance Oversight (CCIIO)	Center for Medicaid and CHIP Services
Waiver applies to	Individual market only	Medicaid population only
Timeframe for approval	Within 180 days after determination of application completion	No defined time period
Cross-program savings	Deficit neutrality calculations will not count any savings accrued from a Medicaid 1115 demonstration	Budget neutrality calculations will not count any savings accrued from a Section 1332 demonstration

State Experiences with Coordinated Waivers

Vermont

- In 2010, Vermont announced plans to create a single-payer health care system by 2017
- The effort would have required a combined 1332 and 1115 waiver as both the individual market and Medicaid would be effected
- In 2014, Vermont announced that they would not be continuing the single-payer plan, citing the projected tax increases required to implement the program

Idaho

- In July 2019, Idaho submitted a Section 1332 waiver requesting to allow individuals between 100-138% FPL to be eligible for exchange subsidies regardless Medicaid eligibility
- The 1332 waiver was submitted in conjunction with an 1115 waiver submitted in August to expand Medicaid
- CMS responded to Idaho saying that their waiver application was incomplete
- In the letter, CMS indicated that they would likely not approve Idaho's waiver upon completion because it was likely to fail the deficit neutrality guardrail

For more information:

Hemi Tewarson
htewarson@nga.org
202-624-7803

manatt

Medicaid Section 1115 Waiver Process

Premiums and Cost Sharing

October 29, 2019

Review: Section 1115 Waivers

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Waiver Overview

Differentiating between Marketplace and Medicaid Waivers

Marketplace Waivers

1332 Waivers

- States may request 1332 waivers from HHS and the Treasury Department of certain provisions of the non-Medicaid provisions in the ACA, including:
  - ✓ Employer mandate
  - ✓ Benefits and subsidies
  - ✓ Exchanges and QHPs
- Guardrails apply relating to coverage, benefits, out of pocket costs and federal costs.
- A 1332 waiver does *not* apply to Medicaid, although they can be submitted at the same time.

Medicaid Waivers

1115 Waivers

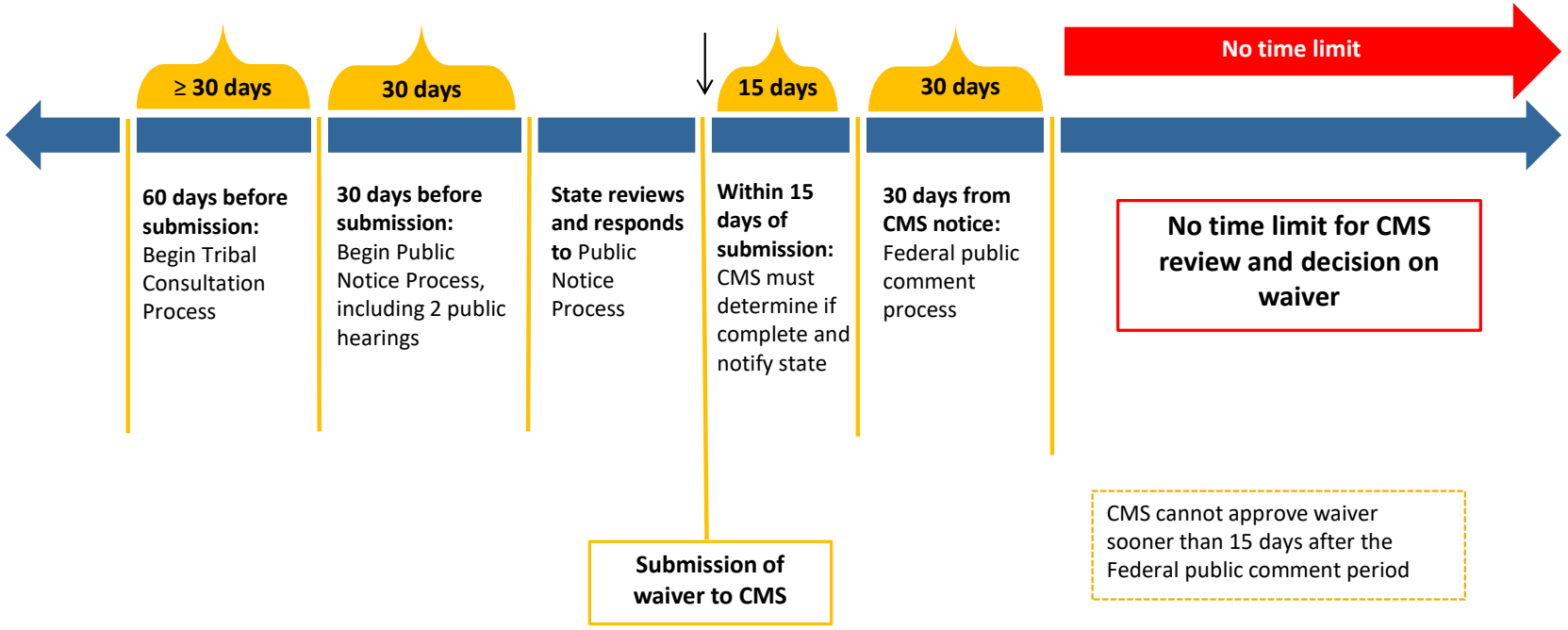
- Authority provided at the Secretary's discretion to allow "demonstration" projects that "are likely to assist in promoting the objectives" of the Medicaid program.
- Can affect Medicaid premiums, eligibility, delivery system, and other program features, but certain provisions of Medicaid law cannot be waived
- Waivers must be budget neutral to the Federal government and independent evaluations are required.

1915 (b) and (c) Waivers

- Section 1915 (b) managed care waivers are one way for states to provide services through managed care or to otherwise limit choice of providers
- Section 1915 (c) Home and Community-Based Services waivers are one way for states to provide LTC in home and community settings (rather than nursing homes)
- States may also apply to use "combined 1915 (b)/(c) waivers"

1115 Waiver Submission and Decision Timeline

The 1115 waiver review and decision process is often lengthy.
There is no time limit for CMS to review and make a decision on a waiver.



Notes: The timeline above reflects changes that the Affordable Care Act (ACA) made to the Section 1115 waiver approval process, requiring more transparency and public input on these waivers. In April 2012, CMS updated the review process for Section 1115 in accordance with Section 10201(i) of the ACA.

Section 1115 Waivers:
Premiums and Lockouts

Medicaid Rules on Premiums

Federal Law (Without a Waiver)

- Premiums are generally not permitted for Medicaid beneficiaries with incomes below 150% FPL ($18,735 for an individual)
- Total out of pocket costs (including premiums and cost sharing) cannot exceed 5 percent of family income

Section 1115 Waiver Authority

- Secretary has authority allow premiums *if it promotes the objectives of the Medicaid program*

Considerations:

- Impact on enrollment and retention
- Level of the premium and income group required to pay premiums
- First payment timing
- Grace periods and exemptions for financial hardship
- Method of payment
- 3rd party Payment
- Administrative cost of collection and tracking

Medicaid Rules on Lock-Out Periods

Federal Law (Without a Waiver)

- Lockout periods are not permitted (all eligible individuals must be served)

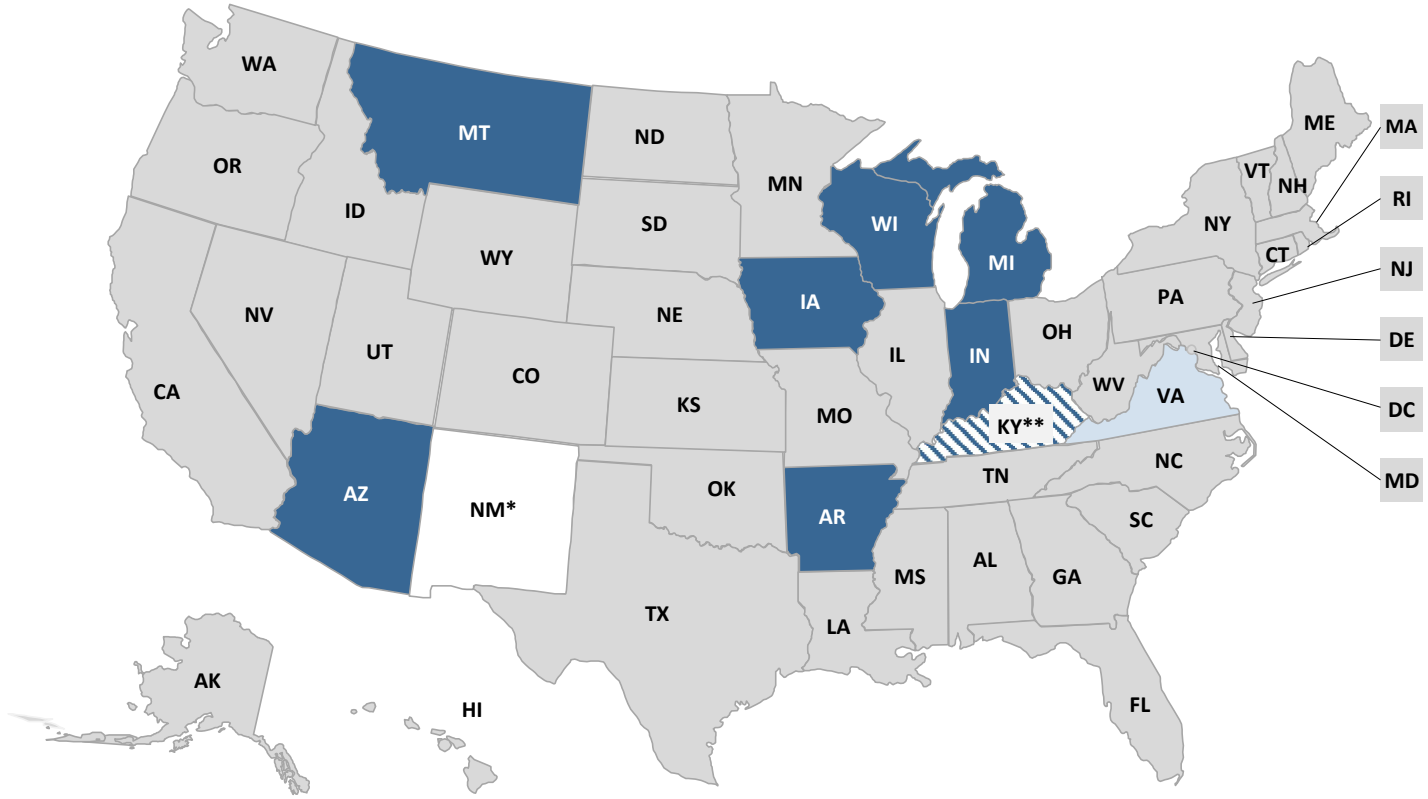
Section 1115 Waiver Authority

- Secretary has authority to allow lockouts *if it promotes the objectives of the Medicaid program.*

Considerations:

- Lockouts result in additional loss of coverage for those prepared to pay premiums
- Could encourage premium payments *if consumers know the rules and have the ability to pay*
- Re-enrollment process and issues
- Coverage losses increase uncompensated care costs for providers.
- Administrative costs

States with Approved and Pending Waivers for Premiums



*Notes: *Subsequent to approval, New Mexico's new Governor submitted a waiver amendment to CMS seeking to eliminate premium requirements, among other changes. **A U.S. District Court judge issued rulings in March and July 2019 that vacated CMS waiver approvals in Kentucky, Arkansas, and New Hampshire (re-approval in the case of the Kentucky). The decision to vacate Kentucky's re-approved waiver stopped implementation of Kentucky's entire waiver, which include premium requirements. Data updated as of 10/20/2019.*

Medicaid Rules on Copayments

Federal Law (Without a Waiver)

- Medicaid beneficiaries with incomes below 100% FPL can be charged "nominal" copays; some groups and some services are exempt. Services cannot be denied for nonpayment
- People with incomes at or above 100% FPL can be charged higher copays
- Total out of pocket costs (including premiums and cost sharing) cannot exceed 5 percent of family income

Section 1115 Waiver Authority

- Secretary has very limited authority to waive Medicaid rules related to copayments*

Considerations:

- Copayments can affect access to care, particularly for those with chronic conditions
- Providers impacted when copays are not collected
- Administrative cost of collection and tracking

*Note: *Under Section 1916(f) of title XIX of the Social Security Act, the Secretary has limited authority to waive Medicaid copayment rules. In order to do so, waiver must test unique and previously untested use of copayments, be limited to a period of no more than two years, provide benefits equivalent to the risks of recipients, be based on a reasonable hypothesis in which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and be voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.*

Effects on Low-Income Populations

Longstanding research finds that premiums reduce heath insurance coverage and access to care among low-income populations. Premium effects are largest among those with very low incomes. For example:

Coverage

- A multi-state study found that among low-income enrollees, premiums as low as 1% of income could reduce enrollment in health insurance by 15%.
- In Oregon, when premiums and co-payments were introduced in 2003 for non-disabled adults with incomes below poverty, enrollment dropped by 77%.

Access to Care

- Studies show that individuals who lose Medicaid coverage due to premiums or premium increases face greater barriers accessing care, have greater unmet health needs, and face greater financial burdens.
- The RAND health insurance experiment demonstrated that premiums and cost-sharing reduced utilization of both effective and less effective services equally.

Health

- The RAND study also found that premiums and cost-sharing was associated with worse health outcomes among the poorest and sickest patients. Care provided without premiums improved hypertension, vision, needed dental care, and other serious symptoms among the poorest and sickest study enrollees.

Sources: Ku & Coughlin., 1999/2000; Wright et al., 2010; Brook et al., 2006.; Artiga et al., 2017.

Evaluation of Indiana HIP 2.0

Healthy Indiana Plan 2.0 members are expected to pay monthly contributions into HSA-like accounts. Members who do not make contributions within a 60-day grace period are offered a more limited benefits package (incomes ≤100% FPL) or disenrolled from coverage and subject to a 6-month lock out period (incomes >100% FPL who are not medically frail or pregnant).

- More than half (55%) of Medicaid enrollees required to make monthly contributions either never made a first payment or missed a payment between February 1, 2015 and November 30, 2016. Individuals with incomes ≤100% FPL were more likely to not make a payment than those with incomes above poverty.
- The two most common reasons for nonpayment among individuals who were disenrolled or never enrolled due to nonpayment were (1) not being able to afford to pay the contribution and (2) confusion regarding the payment process (e.g. unsure how much to pay, when to pay, where to pay).
- Individuals who lost coverage due to nonpayment and those who never enrolled because they did not make their first payment were less likely than individuals enrolled in Medicaid to report making a routine or specialty care appointment or filling a prescription in the past six months or since leaving Medicaid.

Source: The Lewin Group, Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA), Washington, DC: Lewin Group, March 2017.
https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf

Evaluation of Montana Health and Economic Livelihood Partnership (HELP)

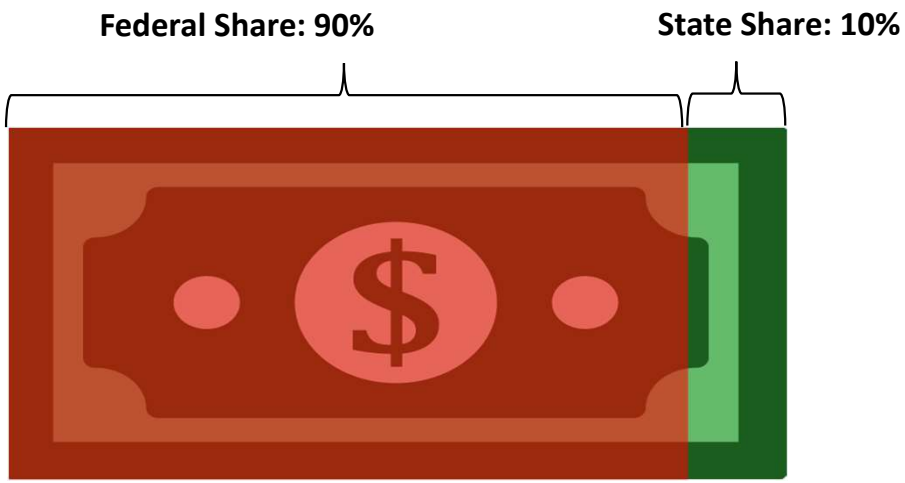
The Montana Health Economic Livelihood Partnership (HELP) Program requires enrollees with incomes from 50% -138% FPL to pay premiums equal to 2% of income (unless exempt). No loss of coverage for nonpayment (but an enforceable debt) for those with incomes below 100% FPL. Individuals with incomes from 100-138% FPL can be dis-enrolled for nonpayment after a 90-day grace period and may re-enroll upon payment of past due premiums.

- Among the 20,050 enrollees required to pay premiums in December 2017, less than half (45%) paid them. Enrollees below poverty were less likely to pay premiums than enrollees above poverty (42% vs. 49%). Payment rates were consistent throughout 2017.
- In December 2017, more than a quarter (28%) of all HELP enrollees who were required to pay premiums had collectible premium-related debt owed to the State of Montana. Of those with collectible debt, 75% percent had income below poverty.
- 2.5% of enrollees subject to disenrollment (income above 100% FPL) were disenrolled for not paying their premiums. According to the evaluation, the low disenrollment rate could be partly attributed to HELP's disenrollment exemptions.

Source: Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Draft Interim Evaluation Report . Social & Scientific Systems; Urban Institute, July 22, 2019.
https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/mt-fed-eval-draft-interim-eval-rpt.pdf

For Expansion States, the Federal Government Receives Most of the Revenue Associated with Medicaid Premiums

Distribution of Revenue from Premiums for Medicaid Expansion Population:



- **Potential state revenue from premiums is also reduced by:**
  - Increased disenrollment attributable to premiums
  - Administrative expenses

State Agency and Health Plan Insights on Implementation of Medicaid 1115 Waiver Premiums

- Researchers conducted interviews with state agency staff and health plan representatives in Iowa and Michigan about their experience implementing Medicaid enrollee premiums under 1115 waivers.
- Key findings include:
  - Difficulty conveying concepts of premiums, account contributions, and retroactively billed cost-sharing in simple, meaningful ways to beneficiaries.
  - Collecting and processing beneficiary payments is a time-intensive, administratively burdensome process.
  - Collecting unpaid premiums as debts to the state required more administrative work than originally anticipated, and in some cases was not yet occurring at the time of the interviews.

> *"Regardless of the waiver program element implemented,[…]implementation involved major administrative efforts, requiring significant coordination among multiple stakeholders, sophisticated IT systems, and ongoing education of beneficiaries."*

Source: Zylla E, et al. Section 1115 Medicaid Expansion Waivers: Implementation Experiences. SHADAC, Feb. 8, 2019. https://www.shadac.org/publications/section-1115-medicaid-expansion-waivers-implementation-experiences

Contact Information

Cindy Mann
Partner
Manatt Health

202.585.6572

cmann@manatt.com

References

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2. Brook R., et al. The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. RAND Corporation, 2006. Accessed October 20, 2019 at: http://www.rand.org/pubs/research_briefs/RB9174.htm

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8. Weiss A. There's A Lot To Learn From State Medicaid Experiments, But Only If They're Carefully Evaluated. *Health Affairs Blog,* March 19, 2018. https://www.healthaffairs.org/do/10.1377/hblog20180314.287490/full/

9. Wright, B., M. Carlson, H. Allen, et al. 2010. Raising premiums and other costs for Oregon Health Plan enrollees drove many to drop out. *Health Affairs* 29(12): 2311–2316.

10. Zylla E, Planalp C, Lukanen E, Blewett L. Section 1115 Medicaid Expansion Waivers: Implementation Experiences. State Health Access Data Assistance Center (SHADAC), February 2018. Accessed October 20 at: https://www.macpac.gov/publication/section-1115-medicaid-expansion-waivers-implementation-experiences/

Healthy Michigan Plan

October 29, 2019

Kathy Stiffler, Director
Bureau of Medicaid Care Management and Customer Service
Medical Services Administration

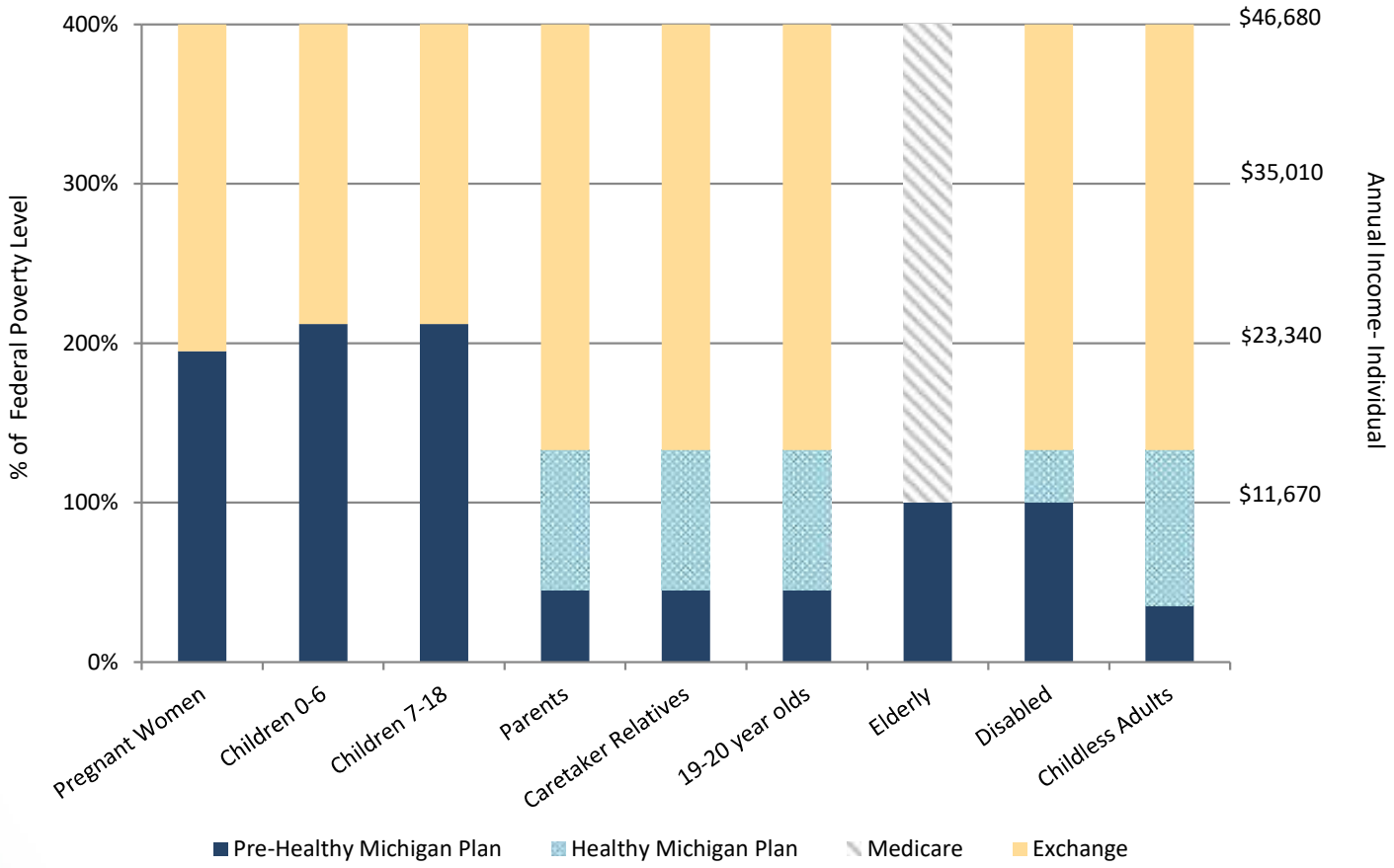
Healthy Michigan Plan Basics

- Program launched in April 2014 after:
  - Passage of PA 107 of 2013, the authorizing state legislation
  - Initial federal waiver approval from the Centers for Medicare and Medicaid Services (CMS), which was received on December 30, 2013
- Extended access to comprehensive health coverage to around 650,000 previously uninsured or underinsured Michigan citizens

Healthy Michigan Plan Goals

- Improve access to healthcare for uninsured or underinsured low-income Michigan residents
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors
- Help uninsured or underinsured individuals manage their health care issues
- Encourage quality, continuity, and appropriate medical care
- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program

Healthy Michigan Plan Eligibility Changes



Unique Features of Healthy Michigan Plan

- PA 107 of 2013 also included incentives for beneficiaries to encourage personal responsibility
- Beneficiary Cost Sharing Requirements
  - MI Health Account for initial collections
  - Garnishment for failure to pay
- Healthy Behavior Promotion
  - Health Risk Assessment
  - Incentives for beneficiaries agreeing to address or maintain healthy behaviors

Cost-Sharing Requirements

- Two types of cost-sharing required in Healthy Michigan Plan:
  - Co-pays
    - For all beneficiaries regardless of income
    - Fixed amounts based on utilization of health care services
    - No co-pays for services related to chronic conditions
  - Contributions (maximum of 2% of income in premium-like payments)
    - For beneficiaries above 100% of the FPL
    - Based on income and family size
- Individuals who consistently fail to pay billed co-pays or contributions are referred to the Michigan Department of Treasury for collection

MI Health Account

- Mechanism to facilitate beneficiary education and responsibility of health care service utilization
- Beneficiaries begin receiving a Quarterly MI Health Account Statement six months after enrollment in a Medicaid Health Plan
- Statements include:
  - Itemization of health services received
  - Cost of services for the beneficiary and the Health Plan
  - Co-pays and/or contributions owed by the beneficiary
  - Any past due amount owed
  - Reductions in cost sharing
  - Payment instructions
  - Health messages

MI Health Account Payments

- Payments can be made:
  - Online using a bank account
  - By mail via check or money order
  - Payment split between 35% online and 65% by mail
- Through March 2019, roughly $18.7 million in contributions have been collected from over 468,000 beneficiaries
- Credit and debit card payment options will be added in April 2020

MI Health Account Payments

- MDHHS partners with the Michigan Department of Treasury for garnishment of beneficiaries who:
  - Fail to pay three consecutive months and owe at least $50; and/or
  - Have not paid at least 50% of their total contributions and co-pays billed to them in the past 12 months
- A program total of $10.4 million has been collected by the Department of Treasury through tax refunds and lottery winnings

Health Risk Assessment

- Beneficiaries who complete a Health Risk Assessment and agree to address or maintain a healthy behavior may be eligible to receive financial incentives:
  - A 50% reduction in their required monthly co-pay amounts (after a set percentage of income has already been paid in co-pays), AND
  - A 50% reduction in required contributions

Health Risk Assessment

- As of June 2019, a total of 418,140 Health Risk Assessments were completed through Michigan ENROLLS, representing a 95.64% completion rate
- 98.2% of the beneficiaries who have completed this process have chosen to either address or maintain healthy behaviors
- 58.2% of beneficiaries chose more than one healthy behavior to address

Healthy Michigan Plan Program Evaluation

- The University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) was granted the contract to evaluate HMP
- IHPI assembled an interdisciplinary team of 17 University of Michigan faculty members across multiple schools and departments to evaluate the HMP program

Evaluation Domains

IHPI's evaluation of the Healthy Michigan Plan is examining six domains:

Uncompensated Care: The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;

Uninsured Individuals: The extent to which availability of affordable health insurance results in a reduction in the number of uninsured individuals who reside in Michigan;

Increase Healthy Behaviors: Whether the availability of affordable health insurance, including coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes;

Evaluation Domains

Personal Health Outcomes: The extent to which enrollees believe that the Healthy Michigan Plan has a positive impact on personal health outcomes;

Use of Services: Whether requiring enrollees to make contributions toward the cost of their health care results in dropped coverage, and whether collecting an average co-pay from enrollees in lieu of copayments at the point of service affects enrollees' propensity to use services; and

Deterrent or Encouragement: Whether providing a MI Health Account into which enrollees' contributions are deposited, that provides quarterly statements detailing utilization and contributions, and allows for reductions in future contribution requirements, deters enrollees from receiving needed health services or encourages enrollees to be more cost-conscious.

Domain 1: Uncompensated Care

- Evaluation findings to date:
  - HMP was associated with substantially reduced costs of uncompensated care provided by Michigan hospitals
  - This reduction was comparable with other states that expanded Medicaid and contrasted with the increase in uncompensated care costs seen in states that did not expand Medicaid over the same period

Domain 2: Uninsured Individuals

- Evaluation findings to date:
  - HMP substantially reduced the uninsured rate for low-income non-elderly adults by 7 percentage points relative to states that did not expand Medicaid
  - Declines were much more pronounced among those with family incomes below 138% of the FPL, for which the proportion that was uninsured fell from 31% to 13%

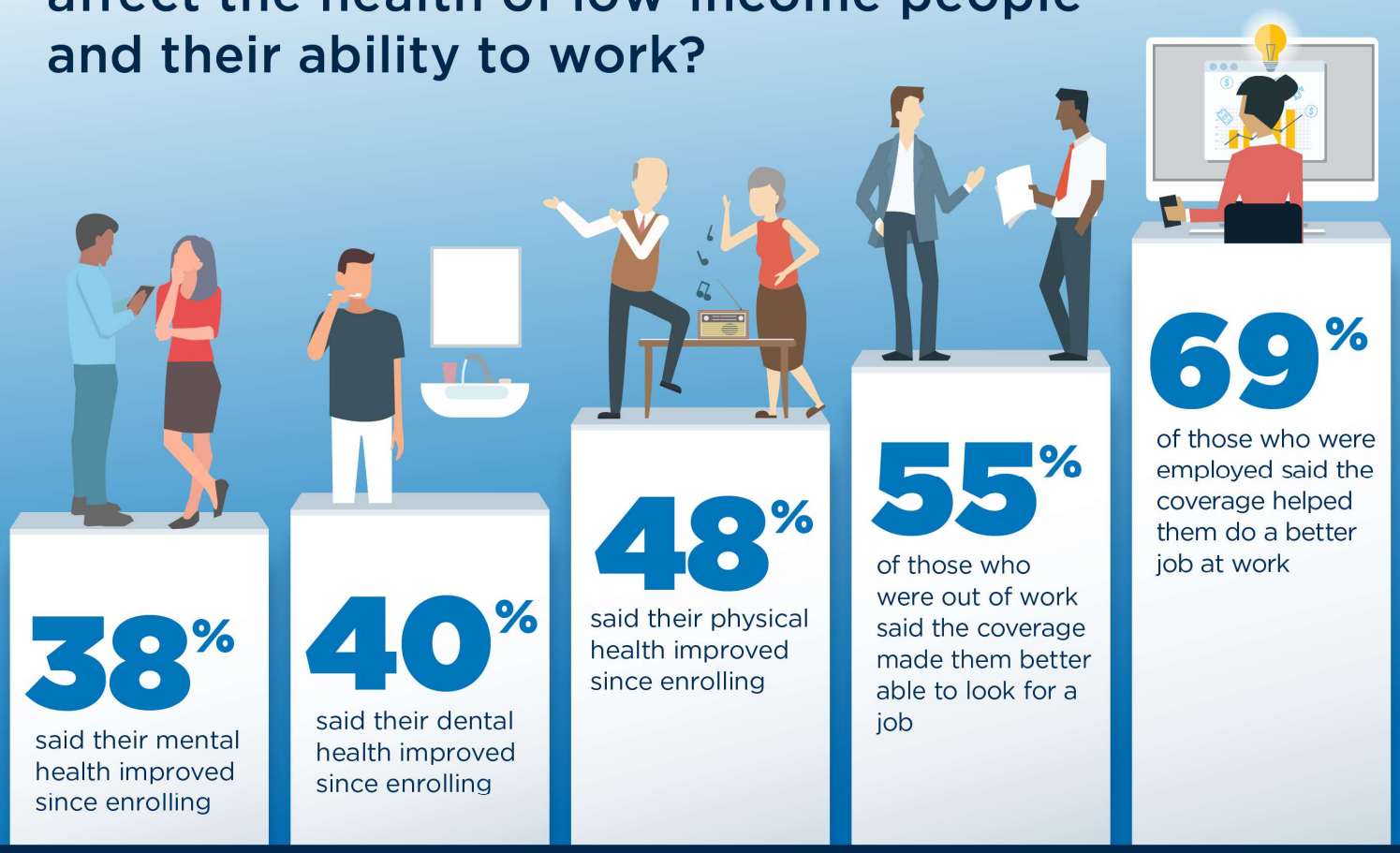
Domain 3: Increase Healthy Behaviors

- Evaluation findings to date:
  - A large majority of HMP enrollees used primary care and preventive services
  - HMP coverage was particularly beneficial for enrollees with chronic health conditions that could be diagnosed and treated more effectively
  - Only one-quarter of HMP enrollees fully completed the Health Risk Assessment (HRA) process, suggesting that HRAs were not a key motivator for use of primary care and preventive services

Domain 4: Personal Health Outcomes

- Evaluation findings to date:
  - Substantial proportions of HMP enrollees reported improved physical, mental, and oral health since enrolling in HMP
  - Many enrollees also reported their ability to work had improved since enrolling in HMP

How did **Michigan's Medicaid expansion** affect the health of low-income people and their ability to work?



38% said their mental health improved since enrolling

40% said their dental health improved since enrolling

48% said their physical health improved since enrolling

55% of those who were out of work said the coverage made them better able to look for a job

69% of those who were employed said the coverage helped them do a better job at work

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Domain 5: Use of Services

- Evaluation findings to date:
  - Monthly contribution amounts may cause increased disenrollment from the plan among those with low medical spending and no chronic conditions, but not among those with higher medical needs
  - The ability to evaluate other key features of this domain was limited by the lack of baseline data on enrollees' health behaviors and use of services prior to HMP enrollment

Domain 6: Deterrent or Encouragement

- Evaluation findings to date:
  - Most enrollees perceived the cost-sharing features of HMP to be fair
  - Cost-sharing requirements may reduce the amount spent by plans and enrollees on medical services, though other causes of the decline could not be ruled out
  - Cost-sharing does not appear to affect the mix of high-and low-value services used in this population
  - The ability to evaluate other key features of this domain was limited by the lack of baseline data on enrollees' health behaviors and use of services prior to HMP enrollment

Additional Analysis: Impact of Healthy Michigan Plan on the State's Economy

- An additional University of Michigan study published in the New England Journal of Medicine in 2017 shows that the Healthy Michigan Plan has boosted the state's economy and budget broadly and significantly
  - The study found that HMP resulted in the creation of over 39,000 jobs in 2016The increased personal income associated with this new employment is estimated to be nearly $2.2 billion in 2016
  - Result: $145 million boost in tax revenue to the state